Health Care Quality Benchmark Subcommittee
Monday, April 2, 2018
9:00 am to 12:00 pm
DHSS Herman Holloway Campus – Chapel
1901 North DuPont Highway, New Castle, DE

Advisory Subcommittee Members Present:

- Secretary Kara Odom Walker (Chair)
- Tim Constantine
- Sharon Anderson
- Jamie Clarke
- Alan Greenglass
- James Gill
- Faith Rentz
- Liz Brown

Advisory Group Members Absent:

- Nancy Fan (or designee)

State Staff Present:

- Steven Costantino, Director of Health Care Reform and Financing, DHSS
- Molly Magarik, Deputy Secretary, DHSS

Primary Consultants Present:

- Michael Bailit, President, Bailit Health
- Dianne Heffron, Principal, Mercer
- Heather Huff, Principal, Mercer
- Jeannie Simpson, NCQA

I. Welcome and Introductions, Secretary Odom Walker

a. Secretary Odom Walker thanked the group for their participation. The Advisory Subcommittee members and staff introduced themselves.

b. The executive order background and purpose of the advisory group and subcommittee were reviewed. Members were reminded that the purpose of the subcommittee is to make recommendations through polite discourse; the subcommittee will not discuss the merits of the executive order.

II. Review of Open Meeting Law, Secretary Odom Walker

a. The subcommittee was reminded that any communication with other Advisory Group members is subject to disclosure through Freedom of Information Act (FOIA) requests, including any communications or meetings outside of this meeting.

III. Charge of the Subcommittee, Michael Bailit

a. The subcommittee charge was reviewed, which is to:

i. Provide input to the Advisory Group regarding the creation of quality benchmarks that will target improvement for no fewer than two and no more than five health care quality improvement priorities for Delaware; utilize measures from recognized

measure developers, such as the National Committee for Quality Assurance (NCQA), or that have been endorsed by the National Quality Forum (NQF); and make use of currently available data sources; be set at the state level and, as practicable, at the market (commercial, Medicare, Medicaid), insurer and health system/provider levels.

ii. Provide input to the Advisory Group regarding the creation of quality benchmarks that will inform benchmark selection by consideration of publicly available benchmark data for the selected measures from the NCQA, the Centers for Medicare and Medicaid Services or comparable national bodies and be established for use for the first time in calendar year 2019, and then, annually thereafter and be used in comparative analysis to actual performance following the end of the calendar year 2019 and annually thereafter.

b. The subcommittee meeting process was discussed, which includes:

i. Meeting once. Additional meetings may be scheduled in May or June depending upon how the Advisory Group's work progresses.

ii. This subcommittee's feedback will be reported to the Advisory Group on April 16.

iii. A separate health care spending benchmark subcommittee will meet this afternoon to address the methodology for that benchmark and will follow a similar process to this subcommittee.

c. The following questions were asked and corresponding responses were discussed on the charge:

i. A question was asked regarding whether 2019 is the baseline for 2020.
Response: No, the charge is to set the benchmark for 2019.

ii. A question was asked regarding how quality benchmarks relate to spending benchmarks.
Response: The executive order does not define the relationship but, if in discussions, the group thinks there should be a connection, then these recommendations can be made.

iii. A couple members stated that their presence at their meeting did not constitute endorsement of or support for the benchmarks.

IV. Criteria for Benchmark Measure Selection, Michael Bailit

a. The group was asked to review meeting materials on "Buying Value" examples of measure selection criteria and make recommendations. The group was reminded that the process will not start with metrics, but with discussing a framework that will help shape those metrics.

b. The group was also asked to weigh in on tying the quality benchmarks to the cost benchmark and the number of measures.

c. The following topics were discussed on criteria for benchmark selection:

i. The quality benchmarks should consider accessibility of care (e.g., not enough providers, social determinants of health such as transportation to care, copays, childcare, etc.).

ii. The measures reviewed are provider-centric, but should also consider the role of payers.

iii. There are existing challenges in the volume and type of quality measures among providers.

iv. It's difficult to make recommendations not knowing how quality interacts with cost measures.

v. Reminder that this is a fluid process, and if measures aren't working, these can be changed.

vi. There were pros and cons discussed related to linking value/cost of care to the quality metrics.

vii. The metrics should capture the entire state population.

d. The following recommendations were made for the benchmark measure selection criteria for individual measures:
    i. Patient-centered and meaningful to patients
    ii. High impact that safeguards public health
    iii. Aligned across programs and payers
    iv. Presents an opportunity for improvement in Delaware
    v. Actionable
    vi. Operationally feasible
    vii. Alignment with the Common Scorecard if meeting other criteria (one member dissenting due to concern that the Common Scorecard falls short on being high-impact and useful).
    viii. Should have financial impact in the short or long term (one member dissenting)
e. The following recommendations were made for the benchmark measure selection criteria for the measure set as a whole:
    i. Include pediatric, adult and Medicare (older adult) populations

V. Candidate Quality Measure Consideration, Michael Bailit

a. DHSS staff suggests that the Advisory Group work from the Common Scorecard measure set when identifying the 2–5 measures that could be used to define the quality benchmarks.
    i. The Common Scorecard consists of 26 quality measures that will be reported by the State in 2018 using data from health plans.
    ii. Data will be reported publicly by the HCC, with analytic support from the DHIN.
    iii. Most of the measures come from the NCQA HEDIS data set. The remainder were derived from other sources (e.g., Pharmacy Quality Alliance) or homegrown.

b. The group was asked to review measures from the Common Scorecard, Medicaid MCO contract and other payer contracts.

c. The following topics were discussed on quality measure consideration:
    i. In reviewing information, it is helpful to have actual percentages because sometimes differences between states are small. It was explained that the percentages cannot be disclosed in full due to NCQA's licensing restrictions but could be shared for individual measures in response to any requests during the meeting.
    ii. It was suggested that accessibility of care should be added to the list of candidate measures (example: a CAHPS survey item).
    iii. Comments were made regarding whether the selected measures should be reflective of State health concerns/priorities from DHSS/Governor's office.
    iv. Patient attribution was discussed. Comments were made that it is difficult to hold providers accountable for members who they are not caring for, and each payer calculates attribution differently. Standardized attribution was suggested, but challenges were acknowledged with trying to standardize this process across different payers/programs.
    v. Composite preventative care measures were suggested for pediatric and adult care. It was suggested that composite measures may make things more complicated.
    vi. Chronic care/chronic disease was noted as a cost driver, so perhaps a measure should address that issue.

vii. It was suggested that the measures focus on where the volume of care is large enough so that the measures can be used in a meaningful way.

viii. A question was asked about the source of data. It was noted that the pending Common Scorecard reporting was believed to reflect Medicaid and State employees' data. The national Behavioral Risk Factor Surveillance System (BRFSS) was suggested as another source of data.

ix. A question was asked regarding how the measures will be used.
Response:
The measures will be calculated at the health system level, but not individual clinician level. The goal is to set a target for the State and then understand what is going on among various health systems, if practical.

x. Existing quality measures in Medicaid MCO contracts were mentioned, which may be aligned with these discussions (e.g., infant mortality [prenatal care], obesity [BMI assessment], preventative care [cancer screening measures]).

xi. There were concerns raised about claims-based measures because only people who receive care will be reflected.

xii. It was suggested that action should be tied to the benchmarks (e.g., pediatrics, specialty care each have a different role in reducing infant mortality, ambulatory care sensitive conditions).

xiii. A question was asked on whether the selected benchmark quality measures will be required to be included in payer/provider contracts.
Response:
There is no requirement for this. The benchmarks are intended to inform the public, payers and providers and to help improve the transparency of the State's progress on improving quality.

xiv. A comment was made that measures should be more outcome-oriented (e.g., obesity rate versus BMI assessment).

d. The following recommendations were made for possible areas of benchmark focus:
   i. Access to care composite from CAHPS 4.0H
   ii. BRFSS access measure
   iii. One or more prevention composite measures (pediatric, adult)
   iv. Potentially preventable hospitalizations
   v. Ambulatory care sensitive condition admissions
   vi. Ambulatory care sensitive condition ER use
   vii. Infant mortality
   viii. Obesity (BMI)
   ix. BMI assessment
   x. Overdose deaths
   xi. Diabetes early detection and treatment
   xii. Depression
   xiii. Oral health access
   xiv. Oral health composite
   xv. Timeliness of prenatal care
   xvi. Equity

VI. Methodology for Defining Benchmarks, Michael Bailit

- **a.** The following was discussed on the methodology for defining benchmarks:
  - **i.** Benchmarks may change over time; metrics may change and level of performance may change.
  - **ii.** There is no standard methodology for how to set the benchmarks. However, many states, health plans and provider organizations choose to set their performance goals relative to best practice, either as achievement of best practice-level performance, or "substantive" or statistically meaningful improvement towards best practice-level performance.
  - **iii.** It was suggested that planning work needs to be done; "throwing numbers may not serve us well."
  - **iv.** The measures should consider year-over-year improvement in additional to aggregate progress.
  - **v.** It was suggested that long-term goals should be set for each measure.
  - **vi.** Improvement measurement should be Delaware-specific.
  - **vii.** The source of data may vary depending on the quality measures that are recommended.
  - **viii.** It was suggested to maintain the same measures for a multi-year period and not change the measures too frequently. Goals for improvement can progressively evolve though.

VII. Public Comment

- **a.** No public comments were submitted.

VIII. Wrap-up and Next Steps, Secretary Odom Walker

- **a.** The second Advisory Group meeting is scheduled for April 16. If additional subcommittee meetings are needed, the group will be contacted.
- **b.** Comments may be submitted via email.